



## ***Texas Department of Insurance***

### ***Division of Workers' Comp***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

CLEAR LAKE REGIONAL MEDICAL CENTER  
3701 KIRBY DRIVE SUITE 1288  
HOUSTON TX 77098

#### **Respondent Name**

TASB RISK MGMT FUND.

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-08-2223-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." "Moreover, the claim was submitted and denied for no authorization. There is an authorization number #0315207001 on file; however, the dates approved are for dates of service: 3/15/07 – 3/21/07. At the time [Claimant] entered our client's facility she advised the hospital that she was covered under another insurance company. The workers' compensation claim and insurance information was not obtained until 3/15/07. At that time, our client contacted TASB to obtain authorization and approval to treat [Claimant]. [Claimant] was on the medical floor for dates of service: 2/28/07 – 3/2/07 and then later transitioned to rehab for dates of service: 3/3/07 – 3/23/07."

**Amount in Dispute:** \$30,866.96

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "[Claimant] was admitted immediately following her injury and the acute inpatient care was paid as a trauma with no pre-authorization required. However, at the point she was transferred to rehabilitation, it was no longer an acute care situation. Clear Lake Regional Medical Center called for authorization of the rehab portion of her stay, but did not call until March 7, 2007 even though she was transferred to rehab on March 2, 2007. Services were authorized for March 7 to March 14, 2007. Services from March 14 to March 27, 2007 were further approved for three hours of physical and occupational therapy per day." "Because [Claimant] was transferred on March 2 and was not charged room and board for that day in the acute care setting, we paid that day as a standard per-diem rate on the rehabilitation bill to fairly reimburse for the transitional period. The remainder of the bill was considered subject to pre-authorization as it was no longer an acute care confinement." "There is no fee schedule set for inpatient rehabilitation. TASB feels our reimbursement of \$1,000.00 per day for the authorized dates is fair and reasonable."

**Response Submitted by:** Lucy Hopkins, TASB, P.O. Box 2010, Austin, TX 78768

## SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2007 through March 23, 2007	Inpatient Rehabilitation Services	\$30,866.96	\$0.00

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on December 3, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 62-Payment denied/reduced for absence of, or exceeded pre-certification/authorization.
  - W4-No additional reimbursement allowed after review of appeal/reconsideration.
  - W3-Additional payment made on appeal/reconsideration.
  - 10/02/07 Per peer review results allowing for a 1 day stay. Copy of peer review sent.
  - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
  - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
  - Previously paid 1 day inpatient on EOMB#1539007. 3/2/07 – 3/4/07 inpatient room & board were not preauthorized. 1 day stay was paid on EOMB#1539007.
  - 10/12/07 3/5/07 – 3/6/07 inpatient rehab was not preauthorized; therefore reimbursement is for 3/7/07-3/23/07 inpatient rehab. Reimbursed at fair and reasonable. This is on a reconsideration that was submitted on original EOMB#1539007. New EOMB created to reimburse 10/12/07 correctly for inpatient rehab days.

### **Findings**

1. This dispute relates to inpatient medical and rehabilitation services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401.
2. The claimant sustained a compensable injury on February 27, 2007, when she tripped and fell resulting in a right lateral tibial plateau fracture. Claimant was admitted to Clear Lake Regional Hospital on February 27, 2007.
3. The respondent does not dispute that initial treatment from February 27, 2007 to March 2, 2007 was for a trauma injury and did not require preauthorization. Once the claimant was transferred to the rehabilitation unit on March 2, 2007, the respondent contends that the admission was no longer an emergency admit and preauthorization was required.
4. The requestor submitted a medical bill for dates of service March 2, 2007 through March 23, 2007, for twenty one inpatient days. A review of the bill indicates that the requestor billed for inpatient medical services from March 2, 2007 through March 5, 2007. Then, from March 5, 2007 through March 23, 2007 for rehabilitation

services. Based upon the submitted Discharge Summary and medical records, the claimant was transferred for inpatient rehabilitation on March 2, 2007. The Division finds that this inpatient hospitalization is applicable to the provisions of 28 Texas Administrative Code §134.401 (a)(2).

5. 28 Texas Administrative Code §134.401 (a)(2), states "Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate..." The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
6. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." The Division has found that in Division rule at 28 TAC §134.401(a)(2) the inpatient rehabilitation shall be reimbursed at a fair and reasonable rate; therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.
7. The respondent denied reimbursement for dates of service March 3, 2007 through March 6, 2007 based upon "62-Payment denied/reduced for absence of, or exceeded pre-certification/authorization." The respondent stated on the position summary that "Clear Lake Regional Medical Center called for authorization of the rehab portion of her stay, but did not call until March 7, 2007 even though she was transferred to rehab on March 2, 2007. Services were authorized for March 7 to March 14, 2007. Services from March 14 to March 27, 2007 were further approved for three hours of physical and occupational therapy per day." The respondent further noted on EOB that fair and reasonable reimbursement was made for dates of service March 7, 2007 through March 23, 2007.

The requestor disagrees with the respondent and contends that additional payment is due because "At the time [Claimant] entered our client's facility she advised the hospital that she was covered under another insurance company. The workers' compensation claim and insurance information was not obtained until 3/15/07."

28 Texas Administrative Code §134.600(c)(1) effective May 2, 2006, states that "c) The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

- (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
- (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
- (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
- (D) when ordered by the Commissioner."

The respondent does not dispute that the initial treatment was for a medical emergency, but when claimant was transferred for rehabilitation on March 2, 2007, preauthorization was required..

28 Texas Administrative Code §134.600(q)(1) effective May 2, 2006, requires preauthorization for concurrent review for an extension of "inpatient length of stay."

The Division finds that the requestor did not obtain preauthorization approval for concurrent review for inpatient hospitalization in accordance with 28 Texas Administrative Code §134.600(q)(1); therefore, additional payment is not recommended for dates of service March 3, 2007 through March 6, 2007.

8. 28 Texas Administrative Code §133.307(c)(2)(C), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the *Table of Disputed Services* finds that the requestor indicates that the respondent has paid \$0.00 for the disputed services. The respondent states in the position summary that "Because [Claimant] was transferred on March 2 and was not charged room and board for that day in the acute care setting, we paid that day as a standard per-diem rate on the rehabilitation bill to fairly reimburse for the transitional period. The remainder of the bill was considered subject to pre-authorization as it was no longer an acute care confinement." "There is no fee schedule set for inpatient rehabilitation. TASB feels our reimbursement of \$1,000.00 per day for the authorized dates is fair and reasonable." A review of the submitted EOBS support payment of \$16,870.00. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under 28 Texas Administrative Code §133.307(c)(2)(C).

9. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
10. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
- The requestor's position statement asserts that "Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%."
  - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(a)(2).
  - The requestor does not discuss or explain how additional payment of \$30,866.96 would result in a fair and reasonable reimbursement.
  - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>9/27/2011</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	<u>9/27/2011</u> Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**